STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING **01, 02** B. WING _____	R **05/12/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CHESAPEAKE	**715 ARGYLL ST** **CHESAPEAKE, VA 23320**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Description of structure: 1 story II (000) Sprinkler status: Fully Sprinklered. An unannounced Life Safety Code revisit to the standard survey conducted on 3 Apr 2015 was conducted on 12 May 2015, in accordance with 42 Code of Federal Regulations for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2000 Health Existing regulations. The facility was in compliance with the requirements for Participation Medicare and Medicaid. Corrected deficiencies are identified on the CMS-2567B.	{K 000}		
{K 000}	(INITIAL COMMENTS Description of structure: 1 story Type II (000) Sprinkler status: Fully Sprinklered An unannounced Life Safety Code revisit to the standard survey conducted on 3 Apr 2015 was conducted on 12 May 2015, in accordance with 42 Code of Federal Regulations for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2000 Health Existing regulations. The facility was in compliance with	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING **01, 02** B. WING _____	R **05/12/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CHESAPEAKE	**715 ARGYLL ST** **CHESAPEAKE, VA 23320**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	Continued From page 1 the requirements for Participation Medicare and Medicaid. Corrected deficiencies are identified on the CMS-2567B. .	{K 000}		